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Community Advisory Board

1991
ANNUAL
REPORT



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MESSAGE FROM THE CHAIR

CAROL GOODING, CHAIRPERSON AND D. WAYNE FYFFE, ADMINISTRATOR

PH

PH can be truly described as an organization in transition, with a vision for the future and a strategic planning process well on its way to outlining a map on how to get there.

As you will read on the following pages, our programmatic approach to specialized services is now well established. Each program is setting goals which are relevant to the hospital's overall mission. And the mission is relevant to provincial priorities for mental health care delivery as outlined in *the Graham Report*.

Managing this transition has not been easy. We are fortunate to have a dedicated and talented staff who can cope with change and maintain that all-important focus on high quality patient care at the same time.

We are also fortunate to have a very committed group of volunteers who serve on our Volunteer Association and on our Community Advisory Board. The services and donations from our Volunteer Association, as well as the advice and guidance of our Community Advisory Board, are invaluable.

A major highlight last year was our three-year accreditation award from the Canadian Council on Health Facilities Accreditation. That we met or exceeded the new national standards for mental health facilities was testimony to the hard work and positive attitude of staff throughout the hospital. As well, it affirmed that our clinical reorganization to a specialized programmatic approach was the right thing to do and that strategic planning is taking us in the right direction.

The Minister of Health appointed Carol Gooding as the new CAB chair and the board appointed its own new chairs to its standing committees; namely, Chris Williams and Margaret Morrison to the Management and Clinical Committees respectively. We were pleased that Doug McAuley agreed to stay on as past chair. We also welcomed Marjorie Martin who, in her capacity as president of Ontario Public Service Employees Union Local 203 was appointed by the Minister of Health as an ex-officio member of the board. Nancy Griffin completed her six-year maximum term and Johnston Young retired after five years of service on the board; we thank them for their unselfish community service. We were particularly saddened by the sudden death of

Gordon Graves last November. Gordon was an extremely active community volunteer who served us well over the past four years. We miss him dearly.

An extensive advertising campaign was undertaken to recruit volunteers for those vacancies and we look forward to the Minister's decision on new appointments on or before the board's May annual meeting.

Board members, who traditionally serve on either the board's Management Committee or Clinical Committee, substantially increased their hospital participation in 1991. (A Nominating Committee meets

as required.) Board members now contribute to the hospital's Strategic Planning, Quality Assurance and Public Relations Committees. We have an excellent board/senior management working relationship and, although the board is advisory only, members feel very involved in the decision-making process at the policy and planning level for all aspects of the hospital's operation. Having representation from all of the regions served by the hospital is particularly valuable in assisting the hospital to remain focused on its mandate as a regional referral centre.

In keeping with our objective of increasing involvement of families and consumers, we continue to encourage the formation of consumer and family advocacy groups, the involvement of families at the delivery level in each program, and the appointment of consumer and family members to hospital committees.

Strategic planning continued to be a central focus in 1991. By year end, we completed the analysis of our previous year's consultation and distributed it (called *Strategic Directions: A Working Document*) to all staff with the proposed revision of our mission statement. In 1992, we expect to finalize the mission statement based on staff feedback and distribute it, with the working



*Carol Gooding
with Wayne Fyffe*

PERSON & ADMINISTRATOR

1 9 9 1 A N N U A L R E P O R T

document, to all stakeholders who participated in the 1990 consultation. The document describes the 12 strategic directions which will form the basis for developing the final strategic plan. The plan will then guide the hospital through the next five years, in keeping with the provincial priorities and mental health plans of each district health council in the regions served by HPH. Since each program's team is familiar with the overall direction of the hospital, you'll find that the programs are continuing to move ahead in tandem with the strategic planning process.

We would be remiss if we did not comment on the impact of the economy on HPH in 1991. From August on, the hospital was forced to concentrate on cost containment as the previously approved budget (for the fiscal year April 1, 1991 to March 31, 1992) was reduced. Once again, our staff rose to the challenge and we are pleased to predict a balanced budget by March 31, 1992. The board and senior management was acutely aware that further economic restraint will impact on the hospital in 1992 and beyond. We remain determined, however, to advocate strongly to maintain an adequate base of funding to ensure high quality care to our patients and a

satisfying work environment for our staff. Furthermore, we do not want to lose sight of the need to complete the strategic plan which is essential to guide us through the tough decisions of the 1990s.

In 1992, we look forward to completing our strategic plan which we hope will be endorsed by all five district health councils and approved by the Mental Health Facilities Branch by year end. We expect to have renewed formal affiliation agreements with McMaster University as well as other affiliated agencies and institutions. Our new Acquired Brain Injury Program should be near completion, subject to delays in construction of new facilities. We hope each of our programs will achieve their goals for improved care and increased emphasis on outreach activities and outpatient care, within the realities of economic constraint. Program management, as an organizational tool, will no doubt receive greater attention in the next year.

We are optimistic that HPH will maintain its role as a leader in the provision of direct patient care, innovative health care delivery models, education and research. We ask for your continued support as we manage change during a period of severe economic constraint.

*We believe... In promoting active research in
diagnosis, treatment
and rehabilitation*



HPH Community Advisory Board: (seated, l-r): Chris Williams, Dr. Susan French, Dr. John Lavery, Wayne Fyffe,* Carol Gooding, Mary Ann McNamara,* Neil Pauls, Patricia Clark; (standing, l-r): Larry Thibideau, Ruth O'Donnell and Margaret Morrison. Absent: Doug McAuley, Dennis Concordia, Dr. David Dawson* and Marjorie Martin*.

* (Ex-officio)

ACQUIRED BRAIN INJURY PROGRAM

Once in operation, this program will provide comprehensive behavioral rehabilitation along a continuum of care to adults who, due to an acquired brain injury, have developed associated behavioral problems, such as extreme difficulties in responding to rehabilitation demands, lack of social inhibitions, and sexual disinhibition. The program will serve both involuntary and voluntary patients. The paucity of behavioral rehabilitation resources, coupled with continuous demand (about eight to 10 people request this service every month) underscores the importance of developing this program.

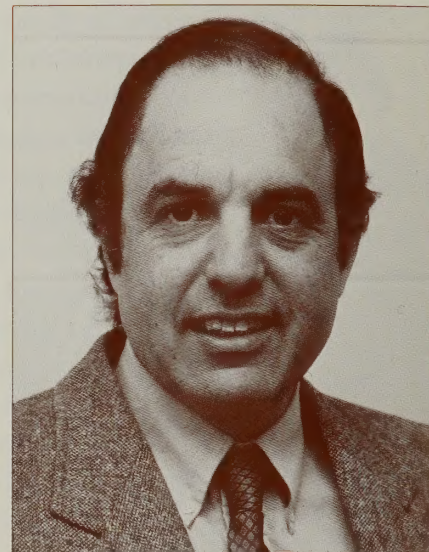
To date, the program's development has been directed by a task force comprising senior clinicians and administrators from both HPH and Chedoke-McMaster Hospitals' Acquired Brain Injury Program. This task force has worked diligently to outline the operating philosophy of the program and to determine the clinical model to be used by reviewing program designs and visiting rehabilitation facilities across Canada and the United States. The task force's conclusion led to the adoption of the clinical model and structure in place at the Centre for Behavioral Rehabilitation at Chedoke-McMaster Hospitals.

The program's service delivery model is theoretically rooted in applied behavior analysis and is known formally as the InterPersonal Treatment Model. This model was designed by program director Dr. Ahmos Rolider and his colleague Dr. Ron Van Houten. Over the past six years, Dr. Rolider focused his research on examining the characteristics and assumptions of this model with individuals exhibiting a range of behavioral difficulties. Using this model, patients can be taught appropriate social inhibitions through a systematic analysis of biological, behavioral and environmental triggers. Using

this analysis, an active rehabilitation program is prepared for each patient which helps establish a therapeutic relationship with specified therapists. Thus, nestled in this model is a prime therapist system of care, in which a prime therapist, with a background in various rehabilitation disciplines and supervised by a behavior analyst, develops, implements and co-ordinates a person's treatment. With this system we will provide our patients and their families with comprehensive rehabilitation tailored to individual needs in both a structured inpatient setting and in the community.

Under the clinical leadership of Dr. Rolider and medical director Dr. Scott Garner, we have recruited psychiatrist consultant Dr. Gian Bartolucci, program consultant Dr. Jane Millichamp, Catherine Hagon as administrative co-ordinator, and secretary Lois Rivers. Given the highly technical nature of the behavioral rehabilitation provided by the program, all staff must undergo extensive training—particularly those who deliver direct care. Staff training will be co-ordinated with the existing educational opportunities found at Chedoke-McMaster Hospitals' Centre for Behavioral Rehabilitation.

Now that the program's philosophy and operating parameters have been developed and agreed to, we expect the full staff contingent to be hired soon and the program to be clinically operational by summer.



*Dr. Ahmos
Rolider
Program Director*

AFFECTIVE DISORDERS PROGRAM



Dr. Rick Guscott
Program Director

The Affective Disorders Program consists of a 32-bed inpatient unit, an outpatient clinic serving about 150 patients and carrying out 20 active consultations at any time, and a satellite clinic which we operate one-half day per week from Chedoke-McMaster Hospitals.

Under the leadership of Dr. Guscott, we made important strides in treating refractory depression and rapid cycling bipolar affective disorder with new antidepressants and mood stabilizers. Those advances were due to our aggressive demand for the most recently approved medications and our commitment

to trying them in combinations. We offer active consultation service to community psychiatrists and family doctors and we have achieved some recognition nationally and internationally for our growing expertise in treatment refractory depression.

Major research initiatives for the next three years are: The evaluation and treatment of refractory depression, the evaluation and treatment of refractory bipolar disorders, and the development of standards for the care of mood disorders in the community.

A Consumer Advisory Group meets monthly to discuss issues affecting our program, and its advice and criticism are well appreciated. Over the past year, they've made recommendations on several issues, including unit renovations and the need for several long stay patients to be more appropriately placed in community nursing homes or other psychogeriatric settings.

In 1991, we worked hard to clarify our admission criteria and procedures to ensure our patients are indeed those who require tertiary care, and we took care to

communicate that information to the community agencies and general hospitals which refer to us. Target dates of three months for inpatient length of stay have been set and, prior to acceptance into the program, referral sources must agree to follow the patient after discharge or accept the patient back to the general hospital after our three month consultation is complete. To provide the continuity of care we believe in, outpatients from our own clinic still receive priority in terms of bed access.

Under the very capable direction of nursing coordinator Peter Kennedy, the program made significant advances in the development of quality assurance, staff education in affective disorders treatment, affective disorders standards, our accreditation manual (which was commended by the HPH Accreditation Review Committee), and multidisciplinary team plans. Dr. Irving Silver and the electroconvulsive therapy (ECT) team continue to offer the best ECT service available and a proposal to expand the outpatient service, which should save on hospital admissions, is now being considered.

As well, we continue to promote awareness and education by providing workshops to community agencies, running an intensive affective disorders course for hospital and community health care workers with our Educational Services Department, and by offering continuing medical education to family physicians. Our social worker, Mary Walsh, very actively supports the Hamilton Manic Depressive Support and Education Group.

What are the long term prospects for the Affective Disorders Program?

This community will ultimately need a regionalized affective disorders program, which would offer an integrated range of services for tertiary and primary care, reflecting the principles elaborated in *the Graham Report*. Hamilton, with its unique psychiatric network, is singularly capable of developing such a system. Our own program is also in the unique position to offer leadership in this area. The opportunities for creativity, innovation and leadership in service delivery are tremendous.

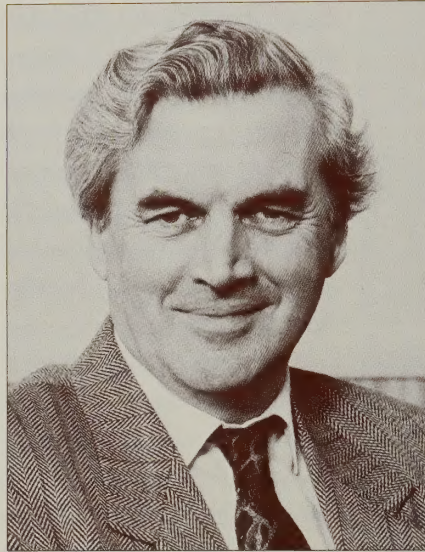
ASSESSMENT PROGRAM

Following a review of its mandate and an analysis of its clinical statistics on admissions over the past two years, the Assessment Program has a more defined goal for clinical services in tertiary care.

The program has reduced its bed complement from 16 to 10 beds. This reduction is warranted: previously we were admitting an increasing number of first-ever admissions to a psychiatric facility although HPH is a tertiary care hospital. Such admissions preferably should be admitted to general hospital psychiatry services.

The analysis of last year's admissions shows a total of 350 admissions. Over 50 percent of these admissions were assessed, treated and returned to continuing care in the community within 20 days of admission. The remaining patients were considered in need of longer term treatment in another of the hospital's specialized programs, to which they were referred.

Two issues have proved of concern over the past year. Although outpatient follow-up is not a requirement of the Assessment Program, an increasing number of outpatients are being treated from the unit while they wait for access to community services. Furthermore, the fluctuating opening and closing of beds in the general hospitals' psychiatric wards directly relate to how the beds on the Assessment Program are used. Such changes have required an ongoing re-evaluation of the program's goals and functioning and this will likely continue in view of the crisis in the admission bed availability that exists in Hamilton-Wentworth.



*Dr. Pat Foley
Program Director*

*We believe... In assuring a high level of quality
in all endeavours undertaken*



COMMUNITY LIAISON PROGRAM

*T*he Community Liaison Program provides general tertiary psychiatric services to adults with psychiatric disorders from the Halton, Haldimand, Brant and Niagara regions. Our belief in quality care extends beyond providing a high standard of service on our inpatient unit; we also try to prepare for that same degree of care once patients have returned home, and thus we actively work with community agencies to encourage effective therapy, communication and education.

Our outpatient team of community workers assists the admission of patients to the program and helps them reintegrate into the community. In Haldimand, where there is no inpatient psychiatric unit, HPH provides two mental health workers to the Adult Mental Health Services clinic in Hagersville. In addition, a psychiatrist from our program attends the clinic one day a week to provide psychiatric supervision for that region's cases. We're also hopeful that we'll provide a community worker to Brant in 1992.

The Community Liaison Program's inpatient component, which consists of 35 beds, is responsible for 40 percent of all admissions to HPH. With a high rate of successful assessment and treatment, the program usually discharges patients rather than transferring them to other programs in the hospital. In fact, due to the active nature of our program, we also accommodate emergency patients from Hamilton-Wentworth's Emergency Psychiatric Service, located at St. Joseph's Hospital in Hamilton.

Overall, the program has undergone a great deal of, what we hope is, positive change. The fact that the program director and nursing co-ordinator have remained consistent has allowed for some maturation of

the program. Also, areas which were previously poorly staffed have improved so that we now have a full complement in social work and occupational therapy. Maintaining that complement and increasing others is vital especially as patient turnover has increased, particularly from sources outside this program's mandate. Keeping in mind the fiscal restraints imposed by the economy, maintaining and increasing our complement will be an ongoing issue for us in 1992.

In conclusion, the Community Liaison Program model emphasizes assessment, treatment and reintegration of patients into the community. It's an active and vibrant program which treats a wide variety of patients, emphasizing education and utilizing an interdisciplinary team approach. We hope that, in the future, we will expand our community services which will allow us to deliver appropriate care in our patients' home communities as well as reducing the reliance on inpatient treatment. We also realize that, as long as the program's beds remain vulnerable to the needs of the local psychiatric network, we may need to develop ways to help the region deal with the continuum of psychiatric care, which would help us to continue to deliver appropriate and humane treatment for our patient population.



*Dr. Gary
Chaimowitz
Program Director*

COMMUNITY LONG TERM CARE PROGRAM



*Dr. John
Deadman
Program Director*

It was said during the Great Depression, "To get a loan from the bank, you have to prove you don't need it." Unfortunately, too many mental health programs take the same approach toward their clients. But Hamilton Psychiatric Hospital has always tried to help the people with the most difficult problems. At HPH, there are no barriers to admissions because the problem is too difficult.

The mandate of the Community Long Term Care Program is to continue that service for those same people, but through follow-up. Each of the program's various components serves the people who are not appropriate for the specific serv-

ices offered by other mental health programs or who present complex problems requiring a special approach. These people are being discharged from HPH or have had HPH follow-up before and require our service again. We focus primarily on schizophrenia.

Our program consists of three components: Consultation, Century Manor Day Program, and Follow-up and Liaison.

Consultations are provided on clinical problems which affect a person's ability to live and function in the community. Using a consultation liaison model, we offer consultation, provide follow-up while the consultation recommendations are being implemented, and attempt to integrate the medical and psychiatric problems of the patient. While we provide this service chiefly to Homes for Special Care residents, we've received excellent co-operation from other HPH programs and particularly from Infirmary staff, who've often helped us with people who have both medical and psychiatric

problems. In addition, we provide psychiatric consultation and back up to the Exit Team and we receive consultation requests for referrals to HPH to determine if admission is indicated.

The Century Manor Day Program offers a comprehensive rehabilitation and maintenance program for a group of people for whom no other services exist in the community. Established in 1981, the program works primarily with outpatients, although we do introduce inpatients to the program when their discharge planning reaches the appropriate point.

Objectives for both the program and for individual treatment plans are: maintenance or improvement of community functioning, quality of life improvement for the most chronic patients, and the capacity to provide psychiatric intervention for people who frequently have crises in their lives. To accomplish these objectives, we work closely with case managers in other follow-up programs.

The program maintains follow-up for a small group who present the most difficult treatment problems and who cannot maintain successful follow-up with other services. They are usually high users of the system who, previously, did not seem to be helped by the treatment services offered. A follow-up approach was then developed for those generally considered poor responders or non-compliant to treatment, including some whose level of social and personal functioning was so low that they could not survive community living without such support.

As part of the liaison function, the program director works at the Schizophrenia Disorders Clinic at the Community Psychiatry Service located at St. Joseph's Hospital in Hamilton.

Our long range plan includes integrating and coordinating the various components of Community Long Term Care with Community Psychiatry Service, and moving a considerable amount of the work to St. Joseph's Hospital where it will combine with the work being done there with chronic patients.



FORENSIC PROGRAM



*Dr. Marcel Lemieux
Program Director*

*T*he Forensic Program assists the judicial system in determining the mental state of a person accused of committing a criminal act. Following assessment carried out in its six-bed inpatient unit, Forensic recommends whether the person is mentally fit to stand trial, if the person was insane at the time of the act or, if found guilty, psychological or psychiatric factors exist which could influence sentencing or rehabilitation.

During 1991, the Forensic Program worked with the judicial system across the five regions HPH serves in the same manner as in the past. Except for its unit

relocation to another floor, Forensic has not essentially changed, in its response or in its organization. We continue to provide in-hospital and community education on forensic psychiatry. We've had the same number of referrals recommended for psychiatric assessments by the court and diagnoses, too, remain consistent with the past—there are, of course a broad spectrum.

There are certain limitations to providing the forensic service. HPH offers minimum security only; therefore, the Forensic Program is excluded from assess-

ing court referrals facing charges of rape, arson or murder which require medium or maximum security.

We predict those requests will keep increasing. The need for consultations will persistently rise, as there has now been sufficient time for the Canadian Charter of Rights and Freedom to impact on our province's associated legislation, such as the Ontario Mental Health Act. While we try to meet the heightened request for service, our experience over the past year revealed that dealing with the medical and legal complexities involved make it increasingly difficult to respond in a timely manner.

Certainly, the new year presents its own set of new challenges: recent amendments to Canada's Criminal Code will change the way in which persons found "not criminally responsible" (previously they were found not guilty by reason of insanity) are managed by our mental health system and other changes to the code will affect patients on Lieutenant-Governors' Warrants. While these changes to the criminal code are intended to ensure that psychiatric hospitals, and not detention centres, look after adults with psychiatric disorders who have come into conflict with the law, the numbers of admissions will rise and increase pressure on existing resources.

To manage these challenges, we will continue to advocate for increased resources so that we may best respond to these very important changes taking place in the field of forensic psychiatry.

*We believe... Our patients
are people first*



The Geriatric Psychiatry Programs of Hamilton Psychiatric Hospital comprise an inpatient program of 30 beds, a hospital-based Community Consultation Team and the Brant County Geriatric Mental Health Outreach Program. The Geriatric Psychiatry Program Co-ordinating Group ensures collaboration in program planning and development between the inpatient and outreach geriatric psychiatry programs. All three have had a very busy and productive year.

GERIATRIC PSYCHIATRY INPATIENT & CONSULTATION PROGRAMS

The HPH Geriatric Psychiatry Inpatient Program admits only those persons with age-related dementia and behavior disturbance requiring tertiary psychiatric assessment and treatment. Admission is based on urgency of need, which has shown a demonstrated increasing efficiency in bed utilization as there is no waiting list. Almost 80 percent of our patients have dementia as their primary diagnosis, compared to 15 percent just three years ago. The residual population of elderly people with severe, chronic schizophrenia continues to decline.

We face an increasingly challenging clinical environment as the acuity of our patients rises. The inpatient program is conducting service evaluation projects, such as a new clinical charting system which will form the basis for the revision of the clinical casebook recommended by the hospital's accreditation surveyors. Several important recreational programming innovations have taken place, including the use of background music to calm agitated patients and specialized programming for the younger patients with frontal lobe dementias. Dr. Jane Dobson joined the program as the second attending physician and also participated in clinical research, including the development of a database. However, as the inpatient program develops, we must respond to the challenges of this changing therapeutic environment through our staffing levels.

The Community Consultation Team continues to

receive more and more referrals, most notably from Niagara, now the only region among the five HPH serves with no organized geriatric health care service. Therefore, the consultation team increasingly functions as a mobile geriatric assessment clinic and is being referred increasingly complex cases that require tertiary geriatric medical and psychiatric assessment. Unfortunately, there are no specialist inpatient resources in geriatric care in Niagara. Therefore, we are admitting proportionally more patients from Niagara to HPH.

Education remains a high priority throughout the programs. Our staff participate in seminars and workshops throughout the region and, throughout the year, we will organize and host educational rounds for all geriatric psychiatry outreach staff in the regions HPH serves. We've been encouraged by the requests to attend from teams outside those areas. We hope these events also will promote closer collaboration and more effective use of available resources.



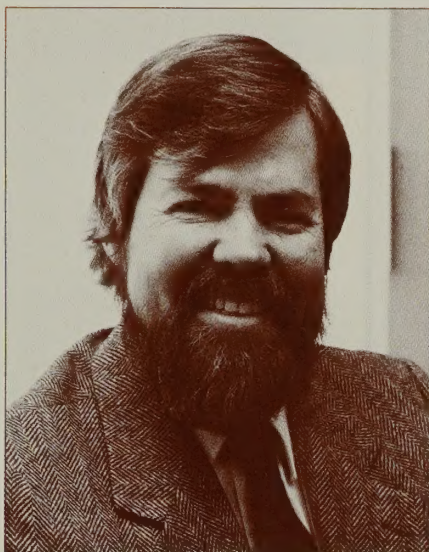
*Dr. Susan Tainish
Program Director*

BRANT COUNTY GERIATRIC MENTAL HEALTH OUTREACH PROGRAM

The Brant County Geriatric Mental Health Outreach Program is a specialized, innovative outreach service of the hospital's Geriatric Psychiatry Program.

Our goal is to improve care for persons with late onset mental health problems with behavioral disturbance through a program of outreach and community devel-

PSYCHIATRY



*Dr. Ken LeClair
Program Director*

opment. The program, located in Brantford yet serving all of Brant County, has been in operation for one year.

The program's major components feature the Home Visit Team (a specialty information resource service) and community development initiatives (pilot projects and activities). The Home Visit Team accepts referrals from a variety of sources, including physicians, community agencies, institutions, residential settings and hospitals. We make our assessments using standardized measure for cognition, function, physical, emotional and mental health as well as behavior, stress and overall patient, family and caregiver out-

comes. We then recommend treatment and management methods to the responsible community clinicians.

The program also offers a specialty information resource service for care providers. It provides indirect consultation on problems and directs clients to appropriate community service. When appropriate, we are also developing learning resource material for community workers.

The pilot development projects work as a collaborative effort between the outreach program and the community agencies involved. The projects will enhance the care of the elderly by developing inhouse resources of the participating organizations and by promoting co-ordination and collaboration of services for this targeted population.

Two pilot projects are already underway. Through consultation with the Brant District Health Council's Long Term Care Committee, the John Noble Home was chosen as the first community institutional pilot.

From the community agency sector, again following extensive consultation, a geriatric mental health community interagency group is being developed to increase understanding among the sectors as well as to enhance education through problem-based learning. This initiative promotes the most effective use of geriatric psychiatry resources to agencies through interagency, intersectorial, interdisciplinary planning, education and care delivery to the community sector.

Health and social care professionals are also being offered a short clinical and educational rotation with the outreach program. This was first offered to the hospital sector to be followed by community agencies and then community institutions. This provides another vehicle to increase the number and quality of local professionals in Brant County able to serve the increasing older population with mental health needs.

From community development to care system issues, our activities have resulted in increasing collaborative dialogue with the local resources in Brant County to begin to identify and implement the most effective means of delivering quality care in the region. The program has also worked collaboratively with the Alzheimer's Society and Seniors Resource Centre. Community consultation will be an ongoing and important process and will be used in formative evaluation of the program.

The support of the people of Brant County, administration and staff of HPH, and McMaster University through the Educational Centre for Aging and Health and the Department of Clinical Epidemiology and Biostatistics have made possible a very successful first year.

In 1992, our priorities will be:

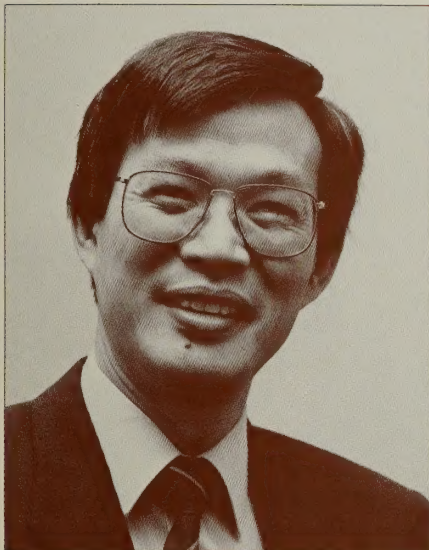
- the implementation of the pilot projects and their subsequent evaluation,
- continuing community development and liaison,
- ongoing development of the specialty information resource service, and,
- co-ordination and integration with local mental health development and long term care reform.

*A*s part of the Geriatric Psychiatry Programs' commitment to research, we presented six papers at the Canadian Association on Gerontology conference in Toronto, most involving interdisciplinary research. Links with Canadian and American researchers continue to be promoted, and the programs are earning a positive national reputation in community outreach and specialized assessment and management of atypical dysfunctional behavior disturbance in dementia.



*We believe... In collaborative planning with all
hospital and community partners*

MEDICAL/SURGICAL SERVICES



*Dr. David Chan
Acting Program
Director*

The Medical/Surgical Services Program at the Hamilton Psychiatric Hospital provides diagnostic services, medical and dental treatment support for the other hospital programs. Specifically, the services also include the Infirmary, Staff Health and Infection Control.

In 1991, we said goodbye to three of our colleagues. Dr. Sonny Tanaka, who had been with HPH for more than 30 years, retired to British Columbia, program director Dr. Patrick Rooney accepted a challenging academic career in Trinidad and, finally, Dr. Peter Eng resigned to devote more time to his growing dental practice. Replacing these people were Drs. Vasiliki Papukna and Imre Szilvassy for the medical side, and Dr. Peter

Wiebe became our new part-time dentist. The rest of the medical team includes Dr. David Chan, acting program director, Dr. Jane Dobson, part-time attending physician to the Geriatric Psychiatry Program, Dr. Joseph Falletta, Dr. Nancy Lee, and our Dental Clinic director, Dr. Gabor Filo. Together they provide inpatient medical and dental care to the other hospital programs, emergency coverage during the day, medical support for electroconvulsive therapy, and support for a number of hospital committees.

To follow the hospital trend of quality assurance, the Medical/Surgical Services physicians started a Clinical Policy Rounds following the monthly departmental committee meetings, to foster dialogue among the physicians on quality of care issues based on review of current literature.

A number of significant achievements were made in 1991 with contributions from the Infection Control Committee, the AIDS Policy Task Force, and, in particular, our Infection Control nurse Marie Wallace. The Body Substance Precautions Program was incorporated into the hospital's general orientation last September. Flu immunization was expanded to include staff. A number of policies on HIV infection control,

testing for HIV infection and protocol related to the Federal Surveillance Program for AIDS were finalized and approved by the Medical Advisory Committee. Infection control policies for Staff Health have also gone through major revisions to keep up-to-date with Ontario Hospital Association recommendations.

The infection rate for 1991 remained low, which can be attributed to good infection control practices among all clinical staff. The Infection Control Committee continued to assess current infection control practices and future needs through surveillance of different clinical and non-clinical areas within the hospital.

Goals for 1992 include implementing changes to Staff Health's infection control policy and updating the Infection Control Manual.

Social worker Pat Saunders and clinical nurse specialist Leslea Anderson joined the Infirmary as part-time staff. Because of the professionalism of staff like Pat Saunders, we experienced one of our most significant achievements this year: the move to community living by several of our long stay patients, people of whom it had been thought would never leave the hospital. Now they are living in community-supported housing, such as nursing homes, quite satisfactorily. Their successful transition can be attributed also to the support provided by our staff to the home operators, long after placement. Such excellent care provided by the hard-working Infirmary staff continues to draw compliments from consumers and their families.

We're also investigating reorganizing the Infirmary. Our aim is to provide the same medical/surgical services within the different hospital programs more efficiently.

In our other services, technicians Cathy Adcock-Willson and Joy Fournier continued to provide on-site diagnostic services which include radiology, electrocardiography, and electro-encephalography. Sylvia Mott, R.N., with help from Mavis Behrue, maintained the usual Staff Health services and expanded the immunization programs. Betty MacDonald, our dental assistant, also keeps the Dental Clinic organized.

M.R./ DUAL DIAGNOSIS PROGRAM

*T*hroughout 1991, we concentrated on precisely defining our program. We believe our purpose is to:

- Provide tertiary services, including specialist assessment and treatment, to developmentally disabled adults
 - Who suffer from psychiatric illness, severe emotional problems or complex behavioral disorders, thought to be related to psychiatric illness,
 - For whom the developmental disability and associated problems complicate the presentation, treatment and prevention of psychiatric illness, emotional and behavioral disorders, and,
 - Who live within the regions served by HPH, and
- To assist each region served by HPH to identify, develop and provide specialist primary and secondary levels of service locally.

To provide effective tertiary care, we believe the health care system must first provide real access to primary and secondary care, both of which imply care delivered with an understanding of our population's specialist needs and particular health vulnerabilities. We have defined this as "specialist health care." Such specialist health care is currently not a reality for adults with a developmental handicap. Without adequate primary and secondary physical and mental health care, or an adequate understanding of specialist health care at these levels, the role of tertiary mental health care for this group becomes somewhat confused. For example, a patient with psychosis was admitted to our unit, only to find that the cause was constipation. This was missed at the primary care level because of the patient's communication problems.

While struggling with these issues, we continued to offer clinical services on our unit and in the community. We envisage our inpatient unit providing specialist backup to community-based tertiary referrals, assessments and treatments (each initiated in the patient's home community and, after assessment and treatment, with follow-up continuing in the same community).

Indeed, this is taking place. We now have fewer

long stay patients compared to one year ago and more patients are being admitted with clearly defined treatment and discharge goals.

A formal proposal has been submitted to assess and develop our outreach activities over two years. In the interim, we'll continue to offer community-based assessment and treatment although, unfortunately, this service is limited—which means two-to-three month waiting lists for non-urgent referrals. Outreach service for new referrals is available to Halton, Niagara, Brant and Haldimand.

New referrals from Hamilton-Wentworth are assessed through the registered outpa-

tient program. This outpatient program is available mainly to patients in Hamilton-Wentworth. Many originally came from other regions but were discharged into Hamilton-Wentworth because of the psychiatric support the community team offers. It offers a high level of mental health support; without it, many patients would still be hospitalized. Actually, this program is a highly specialized secondary level of service which, to be effective, depends on operating locally and developing close working relationships with other local specialists. We envisage that each region served by HPH will develop such specialized secondary levels of service.

Direct clinical service is important; however, to meet the very chronic needs of our patients, we believe awareness of mental health needs and access to ordinary health services must be improved. Educating health care professionals is an essential component of our tertiary role. With two universities and several colleges within HPH boundaries, there's a great opportunity to develop this educational and training role, for both health care professionals and front-line staff.

But change takes time. One which was well worth the wait was our unit renovations. It's much more attractive now: bedrooms have individual washrooms and vanities, there's a kitchen and dining area where patients can maintain and improve skills, and the educational and therapeutic areas have increased. In keeping with our increasing community-based focus, we have a new outpatient area with a number of new outpatient offices. We thank everyone involved who supported this project.



Dr. Elyneth Bradley
Program Director

SCHIZOPHRENIA ASSESSMENT PROGRAM



*Dr. Jorge Soni
Program Director*

In 1987, HPH began to reorganize from a geographical catchmented organization to a programmatic model. As a result, in 1989, three schizophrenia inpatient programs were implemented: the Schizophrenia Assessment Program, the Schizophrenia Intensive Treatment Program and the Schizophrenia Psychosocial Rehabilitation Program. All specialize in research and management. The three programs together are now known as Schizophrenia Services; the Schizophrenia Assessment Program functions as the doorway to the other two.

With 36 beds, between 100 and 120 patients are admitted to the Schizophrenia Assessment Program each year, with an average length of stay of six to eight weeks. Of these, 80 to 90 percent are discharged from the program directly into the community. The remaining 10 to 20 percent are transferred to other

HPH programs or other health facilities.

The main objectives of the Schizophrenia Assessment Program are: to assess individuals who have a provisional diagnosis of schizophrenia, to establish a definite diagnosis of schizophrenia, to initiate or re-establish treatment, and, finally, to reintegrate the patient into the community with the necessary medical, social and occupational support.

Although hospitalization is the only solution in times of a crisis, our program's interdisciplinary team believes it is a stressful event both for the patients and their families. Therefore, we try to shorten their length of stay as much as it is realistically possible.

Together with drug therapy, patients are offered other therapies such as individual supportive and cognitive psychotherapies, occupational therapy, social skills training and family psychoeducation.

During the past year, we have made great strides in developing a program in which the diagnosis of schizophrenia can be made early and accurately, using the latest knowledge and technology available in the field of schizophrenia, and strengthening links with outpatient programs and community agencies to develop a service which functions as a continuum of care for people with schizophrenia.

*We believe... In developing understanding of the disorders
we treat and acceptance of the people affected by them*

SCHIZOPHRENIA INTENSIVE TREATMENT PROGRAM

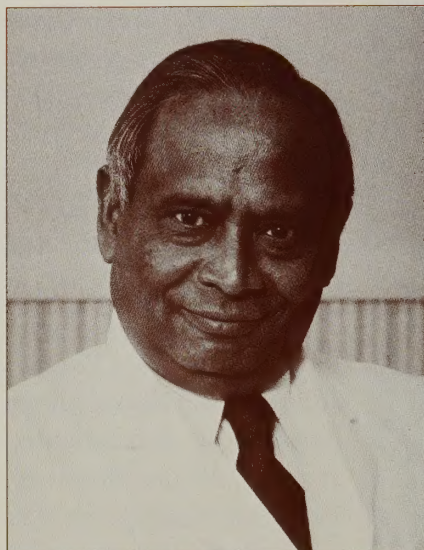
The Schizophrenia Intensive Treatment Program provides therapeutic management for difficult, chronic and unstabilized patients who have a schizophrenic disorder. Treatment includes psychopharmacotherapy, milieu therapy, group therapy, family therapy and, when needed, individualized psychotherapy.

Psychosocial rehabilitation is a strong component of the program, with its goal of preparing patients for re-entry into the community. In conjunction, vocational guidance and training prepare patients for sheltered or competitive employment.

As always, research plays an integral part in patient management on the Schizophrenia Intensive Treatment Program. In 1991, we continued work on two particularly important studies. As part of a multi-centre trial, we're working to find the minimal therapeutic dose with optimal therapeutic benefit and minimal adverse reaction on certain antipsychotics. We're also studying the activities of Benzodiazepine receptors to discover their relationship to the increase or decrease in patients' anxiety intensity.

Admissions, transfers and discharges all increased on this 30-bed program last year, and part of this increased patient flow can be attributed to the closer collaboration between the hospital's three schizophrenia programs. For example, more of our patients transferred to the Schizophrenia Psychosocial Rehabilitation Program. The co-ordination between Schizophrenia Services has been excellent and that change bodes well for our patients, who benefit from more rapid and thorough decision making. To continue to improve efficiency between the programs, we will continue to advocate for the Schizophrenia Assessment Program to move to the same floor as the other two schizophrenia programs.

To improve total patient care, the Schizophrenia Intensive Treatment Program also runs a six-bed Adverse Drug Reaction Program (ADRP) in which we can treat a broad spectrum of adverse effects caused by psychotropic medications. We teach health promotion and drug compliance to both ADRP inpatients and outpatients through individual and group health education,



Dr. Amarendra Singh
Program Director

stress management and relaxation therapy.

Our patients' care is sustained when they return to community living through the close and co-operative assistance of Wellington Psychiatric Outreach Program, and we hope to maintain that special relationship between our program and theirs well into the future.

In the new year, we plan to admit select inpatients to the Adverse Drug Reaction Program just before discharge planning occurs. These patients would have had previous admissions and had to be readmitted because they had abandoned their prescribed drug treatment and become unstable. This, in fact, occurs among 15 to 20 percent of our program's patients. By admitting them to the ADRP pre-discharge, we plan to increase their knowledge and understanding of how important their compliance with their drug treatment is, and thus help them remain in the community for as long as possible after discharge.



*We believe... Our staff is our
most vital resource*

SCHIZOPHRENIA PSYCHOSOCIAL REHABILITATION PROGRAM

The Schizophrenia Psychosocial Rehabilitation Program was established in 1989 to assist patients with schizophrenia acquire the skills and supports necessary for community living. The program focuses on people with schizophrenia who have been institutionalized for long periods or who lack the skills or supports for successful community living. As part of Schizophrenia Services, we envisioned our patients transferring primarily from the Schizophrenia Assessment and Schizophrenia Intensive Treatment Programs.

Since the program's beginning, we took a two-pronged approach. First, we worked with patients who had lived on the unit for, in many cases, long periods of time, to help their community re-entry. In 1990, there were 37 patients aged 25 to 77 with previous hospitalizations of one to 45 years on the unit. Many were not interested in developing new skills, so we worked with them on community orientation, choosing community housing and providing supports.

At the same time, we began developing a psychosocial rehabilitation program for existing patients and for new transfers who wished to learn new skills. We believed that intense work with patients seriously disabled by schizophrenia would prevent their prolonged hospitalization.

What have we accomplished?

With the long stay group, we adopted a strong community focus. We met patients and their families to ask how we could help them move to community living. Many outings resulted to reorient patients to a changed community.

Of the original 37 long stay patients, 18 moved to the community during the program's first 15 months. That group had averaged 17 years of hospitalization prior to the program's start; in fact, one person had been hospitalized for 45 years. Now they live in a variety of community housing. Only one has been readmitted.

Even the average length of stay has dropped. Fifteen months before the program's inception, the average number of days in hospital totalled 451; 15 months after, the number decreased to 371. In addition, a special team has been assigned to work with the remaining long

stay patients to help them make the transition from hospital to community life.

To further our second approach, we built the program around eight key concepts: functioning, environmental specificity, success, satisfaction, choice, outcome orientation, support and growth potential. In our first 15 months, we had 21 patients transfer to the program. Their average age was just under 40, considerably younger than the long stay patients. All have a wide range of skills, symptoms and dreams, and all have difficulty functioning successfully in the community. Several desire to live independently. Therefore, we're developing a housing proposal which supports those patients living in the community — in bachelor apartments in the same building — so they could develop their community living skills while living in the community.

Wherever possible, we try for patient programming in the community. However, we are developing programming specific to the needs of our inpatient population in two areas: Communicating (Group Readiness and Developing Self-Awareness groups have begun and a module on Communication Skills is being developed) and a Wellness Living Module has also started. An adjacent unit is being renovated as a rehabilitation unit, complete with a living skills area, classroom and a bachelor apartment. We hope to move in September.

Families represent a key support for our patients. We always work to increase family involvement, and over the past year our efforts included an orientation and consultation session when the program started, a barbecue and a Christmas party. We hope to increase family involvement further with our changing patient population.



Helen Kirkpatrick
Program Director



PURPOSE

The purpose of the Community Advisory Board shall be to promote community awareness and understanding of mental health issues, identify and respond to the mental health care needs of the communities the hospital serves, and assist the administrator in providing the highest possible standard of care to the patients of Hamilton Psychiatric Hospital by:

1. Establishing and maintaining a close working relationship with all agencies providing services for the mentally ill;
2. Co-operating and consulting with district health councils and other planning groups;

Consolidating information on local mental health needs and concerns, and identifying those which the hospital should address;
Fostering the development of community relations in the areas served by the hospital;
Reviewing and monitoring the hospital's programs in order to determine whether the hospital is meeting the needs of its catchment area; and,
Advising the Minister of Health on important issues which may affect the hospital in fulfilling its mandate to provide high quality mental health services to the regions it serves.

CAB REPRESENTATION

- 1 Carol Gooding
Margaret Morrison
Chris Williams
- 2 Patricia Clark
Dennis Concordia
Dr. Susan French
Doug McAuley
- 3 Gordon Glaves
Ruth O'Donnell
Johnston Young
- 4 Nancy Griffin
Larry Thibideau
- 5 Dr. John Lavery
Neil Pauls



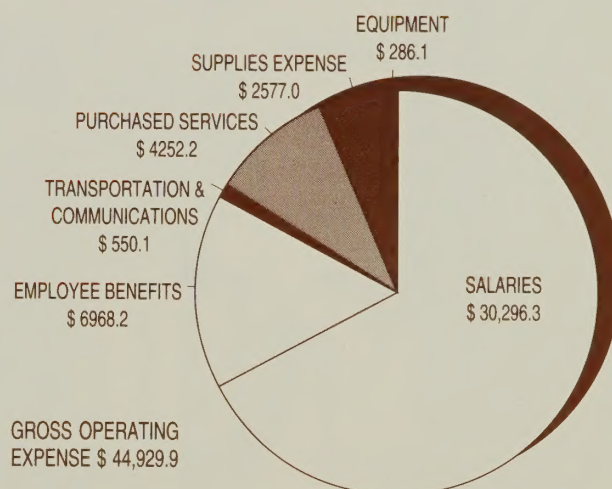
We believe... In respecting individual choices and needs

1991 FINANCIAL STATISTICS

General

	<i>1989</i>	<i>1990</i>	<i>1991</i>
Rated Bed Capacity	502	502	502
Beds Set Up	322	322	287
Workforce Level	769	780	780
Number of Admissions	998	938	700
Number of Discharges	1,025	952	850
Number of Registered Outpatient Visits	22,189	23,079	23,423

1991/92 Forecast



FIGURES ARE BASED ON PROJECTED ACTUAL FOR FISCAL YEAR ENDING MARCH 31, 1992, AND ARE EXPRESSED IN THOUSANDS.

TRANSFERS IN BY HOSPITAL, 1991,

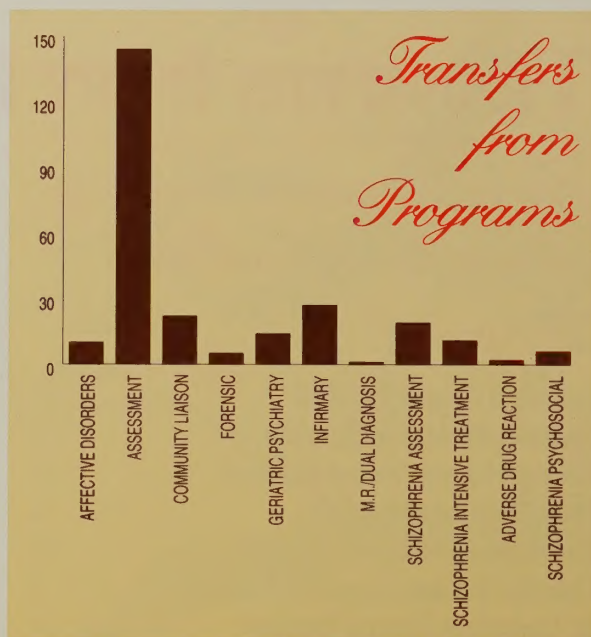
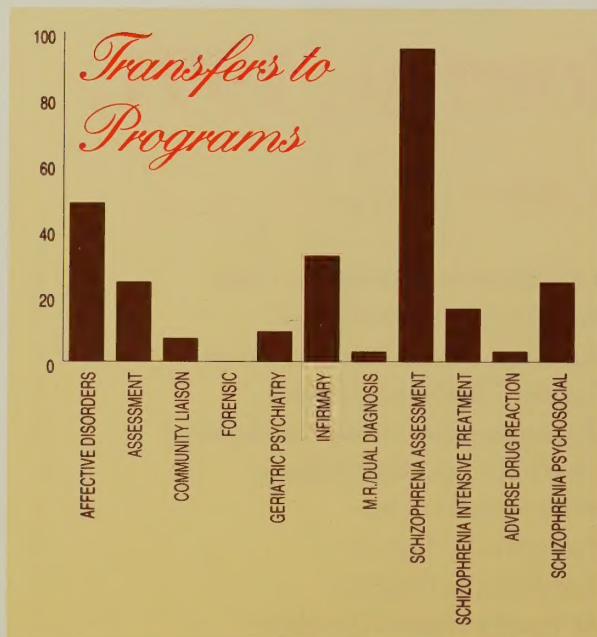
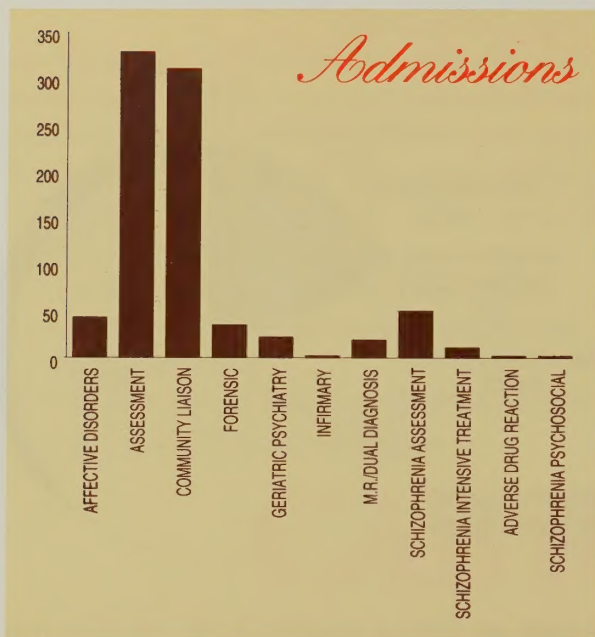
From Regions Served by Hamilton Psychiatric Hospital

Brantford General Hospital	40
Chedoke-McMaster Hospitals	1
Greater Niagara General Hospital	22
Hamilton Civic Hospitals	2
Joseph Brant Memorial Hospital	16
Oakville Trafalgar Memorial Hospital	5
St. Catharines General Hospital	14
St. Joseph's Hospital (Hamilton)	18
Welland County General Hospital	19
TOTAL	137

Other

Grey Bruce Regional Health Centre	1
Kingston Psychiatric Hospital	1
Kitchener-Waterloo General Hospital	1
Lakehead Psychiatric Hospital	1
Penetanguishene Mental Health Centre	3
North Bay Psychiatric Hospital	1
Nova Scotia Hospital	2
Pennsylvania Hospital	1
Royal Ottawa Hospital	1
St. Joseph's Hospital (London)	1
St. Lawrence Psychiatric Centre (U.S.)	1
St. Thomas Psychiatric Hospital	5
TOTAL	19

1991 PROGRAM STATISTICS



design ♦ layout ♦ photography **McMASTER UNIVERSITY AUDIO VISUAL SERVICES**





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for its Community Advisory Board.



Ministry
of
Health

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Relations Publiques
Hôpital Psychiatrique de Hamilton
C.P. 585
Hamilton, Ontario
L8N 3K7
Téléphone: (416) 388-2511, Ext. 4253